

§ 152.15

§ 152.15 Enrollment and disenrollment process.

(a) *Enrollment process.* (1) A PCIP must establish a process for verifying eligibility and enrolling an individual that is approved by HHS.

(2) A PCIP must allow an individual to remain enrolled in the PCIP unless:

(i) The individual is disenrolled under paragraph (b) of this section;

(ii) The individual obtains other creditable coverage;

(iii) The PCIP program terminates, or is terminated; or

(iv) As specified by the PCIP program and approved by HHS.

(3) A PCIP must verify that an individual is a United States citizen or national or lawfully present in the United States by:

(i) Verifying the individual's citizenship, nationality, or lawful presence with the Commissioner of Security or Secretary of Homeland Security as applicable; or

(ii) By requiring the individual to provide documentation which establishes the individual's citizenship, nationality, or lawful presence.

(iii) The PCIP must provide an individual who is applying to enroll in the PCIP with a disclosure specifying if the information will be shared with the Department of Health and Human Services, Social Security Administration, and if necessary, Department of Homeland Security for purposes of establishing eligibility.

(b) *Disenrollment process.* (1) A PCIP must establish a disenrollment process that is approved by HHS.

(2) A PCIP may disenroll an individual if the monthly premium is not paid on a timely basis, following notice and a reasonable grace period, not to exceed 61 days from when payment is due, as defined by the PCIP and approved by HHS.

(3) A PCIP must disenroll an individual in any of the following circumstances:

(i) The individual no longer resides in the PCIP service area.

(ii) The individual obtains other creditable coverage.

(iii) Death of the individual.

(iv) Other exceptional circumstances established by HHS.

45 CFR Subtitle A (10–1–10 Edition)

(c) *Effective dates.* A PCIP must establish rules governing the effective date of enrollment and disenrollment that are approved by HHS. A complete enrollment request submitted by an eligible individual by the 15th day of a month, where the individual is determined to be eligible for enrollment, must take effect by the 1st day of the following month, except in exceptional circumstances that are subject to HHS approval.

(d) *Funding limitation.* A PCIP may stop taking applications for enrollment to comply with funding limitations established by the HHS under section 1101(g) of Public Law 111–148 and § 152.35 of this part. Accordingly, a PCIP may employ strategies to manage enrollment over the course of the program that may include enrollment capacity limits, phased-in (delayed) enrollment, and other measures, as defined by the PCIP and approved by HHS, including measures specified under § 152.35(b).

Subpart D—Benefits

§ 152.19 Covered benefits.

(a) *Required benefits.* Each benefit plan offered by a PCIP shall cover at least the following categories and the items and services:

(1) Hospital inpatient services

(2) Hospital outpatient services

(3) Mental health and substance abuse services

(4) Professional services for the diagnosis or treatment of injury, illness, or condition

(5) Non-custodial skilled nursing services

(6) Home health services

(7) Durable medical equipment and supplies

(8) Diagnostic x-rays and laboratory tests

(9) Physical therapy services (occupational therapy, physical therapy, speech therapy)

(10) Hospice

(11) Emergency services, consistent with § 152.22(b), and ambulance services

(12) Prescription drugs

(13) Preventive care

(14) Maternity care

(b) *Excluded services.* Benefit plans offered by a PCIP shall not cover the following services:

(1) Cosmetic surgery or other treatment for cosmetic purposes except to restore bodily function or correct deformity resulting from disease.

(2) Custodial care except for hospice care associated with the palliation of terminal illness.

(3) In vitro fertilization, artificial insemination or any other artificial means used to cause pregnancy.

(4) Abortion services except when the life of the woman would be endangered or when the pregnancy is the result of an act of rape or incest.

(5) Experimental care except as part of an FDA-approved clinical trial.

§ 152.20 Prohibitions on pre-existing condition exclusions and waiting periods.

(a) *Pre-existing condition exclusions.* A PCIP must provide all enrollees with health coverage that does not impose any pre-existing condition exclusions (as defined in § 152.2) with respect to such coverage.

(b) *Waiting periods.* A PCIP may not impose a waiting period with respect to the coverage of services after the effective date of enrollment.

§ 152.21 Premiums and cost-sharing.

(a) *Limitation on enrollee premiums.* (1) The premiums charged under the PCIP may not exceed 100 percent of the premium for the applicable standard risk rate that would apply to the coverage offered in the State or States. The PCIP shall determine a standard risk rate by considering the premium rates charged for similar benefits and cost-sharing by other insurers offering health insurance coverage to individuals in the applicable State or States. The standard risk rate shall be established using reasonable actuarial techniques, that are approved by the Secretary, and that reflect anticipated experience and expenses. A PCIP may not use other methods of determining the standard rate, except with the approval of the Secretary.

(2) Premiums charged to enrollees in the PCIP may vary on the basis of age by a factor not greater than 4 to 1.

(b) *Limitation on enrollee costs.* (1) The PCIP's average share of the total allowed costs of the PCIP benefits must be at least 65 percent of such costs.

(2) The out-of-pocket limit of coverage for cost-sharing for covered services under the PCIP may not be greater than the applicable amount described in section 223(c)(2) of the Internal Revenue code of 1986 for the year involved. If the plan uses a network of providers, this limit may be applied only for in-network providers, consistent with the terms of PCIP benefit package.

§ 152.22 Access to services.

(a) *General rule.* A PCIP may specify the networks of providers from whom enrollees may obtain plan services. The PCIP must demonstrate to HHS that it has a sufficient number and range of providers to ensure that all covered services are reasonably available and accessible to its enrollees.

(b) *Emergency services.* In the case of emergency services, such services must be covered out of network if:

(1) The enrollee had a reasonable concern that failure to obtain immediate treatment could present a serious risk to his or her life or health; and

(2) The services were required to assess whether a condition requiring immediate treatment exists, or to provide such immediate treatment where warranted.

Subpart E—Oversight

§ 152.26 Appeals procedures.

(a) *General.* A PCIP shall establish and maintain procedures for individuals to appeal eligibility and coverage determinations.

(b) *Minimum requirements.* The appeals procedure must, at a minimum, provide:

(1) A potential enrollee with the right to a timely redetermination by the PCIP or its designee of a determination regarding PCIP eligibility, including a determination of whether the individual is a citizen or national of the United States, or is lawfully present in the United States.

(2) An enrollee with the right to a timely redetermination by the PCIP or its designee of a determination regarding the coverage of a service or the amount paid by the PCIP for a service.

(3) An enrollee with the right to a timely reconsideration of a redetermination made under paragraph (b)(2)